### PRIMARY PPH QUICK REFERENCE GUIDE - DETECT & RESPOND

#### ARE YOU CONCERNED THAT THE WOMAN IS AT RISK OF PRIMARY PPH?

Does the woman have any of the following risk factors, signs or symptoms present?

**Antenatal**
- History of previous PPH
- Uterine distention (e.g. multiple pregnancy, polyhydramnios)
- Anaemia, clotting disorders
- Abnormal placentation (e.g. accreta, praevia)
- Uterine/amniotic infection
- Intrauterine fetal demise (IUFD)

**Intrapartum/Postpartum**
- Prolonged first, second, and/or third stage
- Arrest of descent
- Cervical, uterine or perineal lacerations
- Instrumental birth (forceps or vacuum)
- Syntocinon infusion for augmentation or IOL
- Retained or incomplete placenta or membranes

*NOTE: Two thirds of cases of Primary PPH cannot be predicted.*

The most important single warning of diminishing blood volume and mild shock is tachycardia. This often precedes a fall in blood pressure.

**Record observations on the Standard Maternity Observation Chart - SMOC**

---

#### DETECTION

<table>
<thead>
<tr>
<th>Red Zone observations OR</th>
<th>Yellow Zone observations OR</th>
<th>Severe Primary PPH is present</th>
</tr>
</thead>
<tbody>
<tr>
<td>blood loss ≥1500ml OR</td>
<td>blood loss ≥1000ml OR</td>
<td>This woman is at risk of further deterioration</td>
</tr>
<tr>
<td>additional criteria OR</td>
<td>additional criteria OR</td>
<td>immediate escalation to a medical officer (as per local CERS protocol)</td>
</tr>
<tr>
<td>serious clinician concern</td>
<td>clinician concern</td>
<td>measure / weight blood loss</td>
</tr>
</tbody>
</table>

**YES**

Severe Primary PPH and symptoms of SHOCK are present
- This is a life threatening maternal emergency
- This woman is at risk of rapid deterioration
  - Call immediately for a Rapid Response (as per local CERS)
  - Measure / weight blood loss
  - Commence management as per Primary PPH Quick Reference Guide - Management
  - Monitor for signs and additional causes of deterioration

**YES**

Severe Primary PPH is present
- This woman is at risk of further deterioration
  - Immediate escalation to a medical officer (as per local CERS protocol)
  - Measure / weight blood loss
  - Commence management as per Primary PPH Quick Reference Guide - Management
  - Monitor for signs and additional causes of deterioration

**YES**

Primary PPH is present
- Act promptly to prevent deterioration
  - Call for assistance
  - Do not leave the woman
  - Increase maternal observations/assessments
  - Commence basic measures as per Primary PPH Quick Reference Guide - Management

Escalate and commence full resuscitation measures if bleeding continues despite the above OR **YELLOW** or **RED ZONE** observations/criteria occur.
Maternity – Prevention, Detection, Escalation and Management of Primary Postpartum Haemorrhage (PPH)

GUIDELINE

Primary PPH Quick Reference Guide - Management

Basic measures – for all women when a PPH is detected
- Call for assistance
- Lie the woman flat
- Repeat or give oxytocin (Syntocinon)
- Keep the woman warm
- Ensure the woman’s bladder is empty
- Repair genital trauma if indicated
- If the placenta is delivered: evaluate uterine tone, expel clots, fundal massage
- Inspect placenta & membranes for completeness
- Monitor BP, P, RR, and SpO2 every 5 mins & Temp every 15 mins

Gain IV access & send urgent:
- Group and hold
- CBC
- Coagulation screen
- Consider:
  - Cross match (4 units)
  - LFT, LECs
  - Ca2+, lactate

If bleeding continues or signs of shock despite basic measures – commence full resuscitation & treat the cause
- Escalate as per local CERS
- O2 via mask (10-15L/min)
- Insert IDC – monitor output (i.e. >30ml/hr)
- Give maximum of 3.5L warmed fluids
- Consider blood transfusion early. Give O-RD neg blood (or group specific if available) if bleeding ongoing after 3L of fluids infused
- Re-test Coag, CBC, Ca2+ and ABO’s every 30-60 minutes while active bleeding continues

Identify the cause

(TISSUE)
- Placenta out & complete?
  - Yes
  - No

(TONE)
- Fundus firm?
  - Yes
  - No

(TRAUMA)
- Genital tract & uterus intact?
  - Yes
  - No

(THROMBIN)
- Blood clotting?
  - Yes
  - No

Treat the cause immediate management

- Do not massage uterus
- Ensure 3rd stage oxytocin given
- Apply CCT & attempt delivery of placenta
- Stop undue traction required
- Remove placenta if retained in vagina
- Post delivery: check for completeness, massage fundus – assess tone
- Transfer to OT for:
  - Manual removal/EUA of retained placenta or products

- Uterine massage
- Expel uterine clots
- Give 1st line drugs:
  - 40 units Syntocinon intravein of NSalone or Hartmanns.
  - Infuse at 25ml/hr (warmed)
  - Ergometrine 250mcg IM
- If bleeding continues:
  - Consider Bimanual compression
  - Give 2nd line drugs:
    - Dinoprostone (Prostin F2 alpha)
    - OR
    - Carboprost (15 methyl prostaglandin F2 alpha_)
  - Inspect cervix, vagina, perineum and repair trauma
  - Assess for uterine inversion and replace if found
  - Transfer to OT if:
    - Uterine rupture suspected
    - Haemoglobin unable to see/access trauma site

Massive PPH (i.e. blood loss >2000mls or signs of severe shock)

- Review criteria for activating Massive Transfusion Protocol (MTP)
- Transfer to OT
- Maintain facial oxygen
- Bimanual compression
- Senior multidisciplinary team
- Consider:
  - Intrauterine balloon tamponade
  - Angiographic embolisation (if available)
  - Laparotomy:
    - Interim aortic compression
    - B-Lynch compression suture
  - Bilateral uterine artery ligation
  - Hysterectomy

After the emergency

- Consider transfer to a higher level of care as per local CERS
- Develop a care plan for ongoing care and follow-up
- Documentation: actions, responses and outcomes
- Consider reporting requirements, debriefing with staff and disclosure with the woman.

Severe PPH increases the risk of VTE. Review criteria for VTE prophylaxis